Surgical Eye Care, P.A.  **Alan W. Brown, M.D.**
Richard Dax Hawkins, M.D.

PATIENT ACKNOWLEDGEMANT OF RECEIPT OF HIPPA NOTICE

I have been given and read the "Notice of Privacy Practices" for Surgical Eye Care, P.A., effective date April 14th, 2003. _____ **(Initial)**

I can request a paper copy of the "Notice of Privacy Practices" at any time from this office._____**(Initial)**

Is Surgical Eye Care, P.A. allowed to leave messages on your answering machine regarding your appointments?

Yes _____ No _____

AUTHORIZATION FOR USE AND/OR RELEASE OF INFORMATION

I allow my medical information to be used by and/or released to the following family members, doctors, or other entities I list below.

_____ _____ _____

_____ _____ _____

RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at the time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may be no longer protected by federal state or federal law. Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule. I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification to the address below. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

PRINT NAME: _____ **(SELF, PARENT, OR GUARDIAN)**
SIGNATURE: _____ **(SELF, PARENT, GUARDIAN)**
DATE: _____

A current Notice of Privacy Practices for Surgical Eye Care, P.A. is also available at the check-in counter.